

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

### SLEEP/WAKE SYMPTOMS AND COMPLAINTS

INSTRUCTIONS: Circle YES or NO, or fill in the blanks as appropriate.

1. Describe your major sleep/wake complaints: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- |  |       |       |     |    |
|--|-------|-------|-----|----|
| 2. What time do you usually go to bed?                           | _____ | AM/PM |     |    |
| 3. What time do you usually get out of bed?                      | _____ | AM/PM |     |    |
| 4. Do you have difficulty falling asleep?                        |       |       | YES | NO |
| 5. Do you wake up often during the night?                        |       |       | YES | NO |
| 6. Have you been told that you snore?                            |       |       | YES | NO |
| 7. Have you been told that you stop breathing while asleep?      |       |       | YES | NO |
| 8. Do you have a problem with daytime sleepiness?                |       |       | YES | NO |
| 9. Do you wake up feeling rested?                                |       |       | YES | NO |
| 10. Have you ever had a car accident because of sleepiness?      |       |       | YES | NO |
| 11. Have you ever had a convulsion (seizure, epilepsy) at night? |       |       | YES | NO |
| 12. Do you usually sleep with a bed partner?                     |       |       | YES | NO |
| 13. Are you a restless sleeper, tossing and turning at night?    |       |       | YES | NO |
| 14. Do you do anything unusual in your sleep (walk, talk, etc.)? |       |       | YES | NO |

If yes, please describe: \_\_\_\_\_

- |   |  |  |     |    |
|---|--|--|-----|----|
| 15. Do you sweat excessively when you sleep?      |  |  | YES | NO |
| 16. Do you regurgitate or vomit during the night? |  |  | YES | NO |
| 17. Do you have chest pains during the night?     |  |  | YES | NO |
| 18. Do you frequently awake with headaches?       |  |  | YES | NO |
| 19. Have you ever had a head injury?              |  |  | YES | NO |

If yes, please describe: \_\_\_\_\_

- |   |  |  |     |    |
|---|--|--|-----|----|
| 20. Do you seem to be losing your sex drive?  |  |  | YES | NO |
| 21. Do you have trouble concentrating or remembering things?                        |  |  | YES | NO |
| 22. Do you feel unusually ill or irritable?   |  |  | YES | NO |
| 23. Do you feel short of breath during the day or at night?                         |  |  | YES | NO |
| 24. Do you suddenly go limp or fall asleep if you are angry, laughing or surprised? |  |  | YES | NO |
| 25. Do you sleep with your head elevated?   |  |  | YES | NO |
| 26. Do you usually take naps during the day or evening?                             |  |  | YES | NO |
| 27. Have you been told your legs kick or move while you sleep?                      |  |  | YES | NO |
| 28. Do you often have pain, cramps, or discomfort in your legs?                     |  |  | YES | NO |
| 29. Do you often wake with heartburn?   |  |  | YES | NO |
| 30. Do you use antacids on a regular basis?   |  |  | YES | NO |

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? (Even if you have not done some of these things recently, try to work out how they would have affected you). Use the following scale to choose the most appropriate number for each situation.

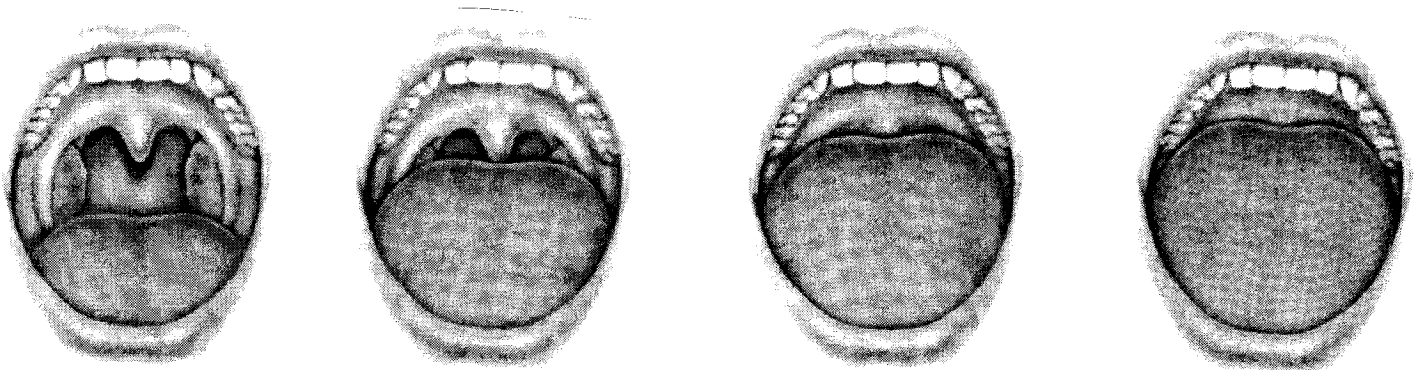
- 0-would never doze
- 1-slight chance of dozing
- 2-moderate chance of dozing
- 3-high chance of dozing

SITUATION

CHANCE OF DOZING

- |   |       |
|---|-------|
| 1. Sitting and reading                                  | _____ |
| 2. Watching television                                  | _____ |
| 3. Sitting inactive in a public place such as a theater | _____ |
| 4. As a car passenger for an hour without a break       | _____ |
| 5. Lying down to rest in the afternoon                  | _____ |
| 6. Sitting and talking to someone                       | _____ |
| 7. Sitting quietly after lunch without alcohol          | _____ |
| 8. In a car while stopped at a traffic light            | _____ |

A score of greater than 10 is a definite cause for concern as it indicates significant excessive daytime sleepiness.



A

B

C

D

Tonsil Grade=

BMI=

HT:

WT:

$$RDI = 7.816 \times MMP + 3.988 \times \text{Tonsil Size} + 4.675 \times \text{BMI} - 7.544$$

NECK CIRCUMFERENCE